No. 48666-1-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

ALICE KARANJAH,

Respondent

v.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND
HEALTH SERVICES,

Appellant.

RESPONDENT'S REPLY BRIEF

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I. INTRODUCTION

In 2014, the Superior Court remanded this case to the Department of Social and Health Services ("DSHS," the "Department," or the "agency") to determine whether Ms. Karanjah's actions regarding Ivan were "reasonable," under *Brown v. Dep't of Soc. & Health Servs.,* 145 Wn. App.177, 185 P.3d 1210 (2008), "in light of the surrounding circumstances...." The Department, however, has again failed or refused to conduct this analysis. Instead, it attempts to shift the burden of proof and require that Ms. Karanjah affirmatively prove self-defense, like in a criminal matter.

There is insufficient evidence to show that Ms. Karanjah's actions resulted in an actual bodily injury or constituted physical mistreatment. On the contrary, her actions were protective, non-injurious, and not ill-intended. For these reasons, as well as the reasons articulated in the Opening Brief, which Ms. Karanjah incorporates herein, the Court should affirm the Superior Court's reversal of the Department's abuse finding.

II. ARGUMENT

A. The Department's Statement of Fact Misleads This Court.

1. The Department Misrepresents the Record[1] Regarding the Department of Health (DOH) Stipulation to Informal Disposition.

In its Response Brief, the Department blatantly misrepresents that the DOH "determined that Ms. Karanjah violated nursing assistant regulations." Response Brief 7, 42-43. However, as noted in Ms. Karanjah's Opening Brief, she and DOH resolved the licensing investigation through a Stipulation to Informal Disposition.[2]

The stipulation explicitly states that it "is **not** a formal disciplinary action." AR 331. (emphasis added). DOH executed the stipulation under RCW 18.130.172, which provides that "a stipulation entered into pursuant to this subsection **shall not** be considered formal disciplinary action." (emphasis added). There is no finding by the DOH that Ms. Karanjah violated nursing assistant regulations. To state otherwise is a misrepresentation of the record.

Here, Ms. Karanjah successfully complied with the terms of the stipulation, without any admission or findings of fact. AR 335-38. At least

[1] AR" is reference to the Administrative Record; "CP" is reference to the Clerk's Papers. Pages 87-105 of the Administrative Record appear as separately designated.

[2] The Department also disingenuously asserts that "DOH determined that the facts of this case 'constitute grounds for discipline under RCW 18.130.180(4), (7) and WAC 246-841-400(4)(a), (c), and 6(g).'"Response Brief at 42. The Department omits the context for that partial quotation, which comes from paragraph 1.3 of the Stipulation to Informal Disposition. That paragraph, in its entirety, reads: "[Ms. Karanjah] acknowledges that a finding of unprofessional conduct or inability to practice based on the above allegations, ***if proven***, would constitute grounds for discipline under RCW 18.130.180(4),(7) and WAC 246-841-400(a), (c), (d) and 6(g)." AR 330. (emphasis added). DOH has never made a finding of "unprofessional conduct," or "inability to practice," regarding Ms. Karanjah, and the Department's attempts to insinuate otherwise are false.

insofar as DOH is concerned, "the complaint is deemed disposed of." RCW 18.130.172.

2. The DOH Stipulation to Informal Disposition Fully Supports Ms. Karanjah's Position That Ivan Was Not Harmed.

Without any factual support and citation to the record, the Department nevertheless asserts, "DOH determined that Ms. Karanjah committed incompetence, negligence or malpractice which caused an injury or created an unreasonable risk." Response Brief at 43. Again, no such DOH adjudication ever occurred. Ms. Karanjah and DOH stipulated that the conduct alleged fell in Tier A of the "Practice Below Standard of Care" sanction schedule. AR 331; WAC 246-16-810. Conduct falling in Tier A is that which "cause[s] no or minimal harm or a risk of minimal patient harm." WAC 246-16-810. See also APPENDIX 1, WAC 246-16-810 "Sanction schedule—Practice below standard of care."

Notably, DOH did **not** apply the sanction schedule in WAC 246-16-830 regarding "Abuse—Physical and Emotional." DOH determined that the sanction range associated with Tier A did "adequately address the alleged facts of this case." DOH identified "factors that justify a sanction that falls toward the bottom of that identified tier." AR 331-32. Among the factors that DOH identified was that: "**there was no harm to the Resident.**" AR 332. (emphasis added).

3. The Department Mischaracterizes the Review Judge's Credibility Determination.

The Department asserts that the Board of Appeals (BOA) Review Judge determined that Ms. Karanjah was "not credible." Response Brief 20. That determination, however, was specific and limited to her testimony on how she restrained Ivan. AR 6. The ALJ and the BOA found Ms. Karanjah's written statements, dated January 3, 2011, and March 15, 2011, to be among the "most credible evidence of what occurred." *Id.*

The BOA made this finding in part because the written statements were "closer in time to the date of the incident and they were against her interests." *Id.* Those written statements describe the many dangers that Ivan posed. Additionally, these descriptions are consistent with Ivan's nursing progress notes, which reflect serious behaviors. Such behaviors include aggression toward staff, wandering into other resident rooms, being found in bed that evening with a partially paralyzed female resident, a tendency to undress completely, refusing care, and being hard to redirect. AR 229.[3]

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[3] Additionally, while the Court may not make credibility determinations on judicial review, the Court has the authority to determine whether there is substantial evidence to support *each* finding of fact, when reviewing *all* the evidence in the record. *Dana's Housekeeping, Inc. v. Dep't of Labor & Indus.*, 76 Wn. App. 600, 605, 886 P.2d 1147, 1150 (1995), *recon. denied, rev. denied* 127 Wn.2d 1007 (1995).

B. Ms. Karanjah Intervened in Response to Danger.

As the Superior Court concluded in its remand order, Ms. Karanjah did intentionally restrain Ivan. CP 547. In her 2012 and 2014 testimony, Ms. Karanjah disputed that she pushed Ivan down the hallway with his hands interlocked behind his back. CP 423-24; 517-518. She also, however, described how she grabbed his wrist and arm (over his shoulder) to escort him to his room. CP 420-23; 498-99. She acknowledges that this constituted physical restraint. The question on remand, however, is whether that restraint, even as the BOA erroneously described it in its findings of fact, was "reasonable" under *Brown*, "in light of all of the surrounding circumstances." CP 548-549.

The Department asserts that "*Brown* does not give caregivers like Ms. Karanjah license to prophylactically restrain vulnerable adults whenever they subjectively believe that such restraint may be 'protective.'" Response Brief 28. This position attempts to excuse the BOA from addressing all of the surrounding circumstances that the Court instructed the Department to consider on remand. The Department ignores facts such as Ivan setting off alarms "all the time" (which the evidence established he did again a mere two hours after his encounter with Ms. Karanjah). CP 417. It also ignores his disconnecting of oxygen tanks in other patient rooms. AR 8, AR 339, CP 417-18.

The Department's argument avoids considering the partially paralyzed woman whose bed Ivan had visited uninvited approximately one hour before the incident in question. AR 8. Similarly, the Department's argument fails to acknowledge that the facility's Director of Nursing considered Ivan to have been above the facility's level of care. AR 345.

Ms. Karanjah did intervene in the presence of danger. The Department ignores the reality that she and Ms. Varney were the only trained staff[4] in one of the facility's two buildings that night. CP 403-04. Leticia Simmons, the night shift supervisor was in the other building. CP 403, AR 347. Ms. Karanjah also had the safety of other residents to consider, as there were approximately 60 residents in the facility. CP 403.

Ms. Karanjah explained why she did not just leave Ivan in the hallway after the situation with Ms. Harris had calmed down. She stated that he was in an "unacceptable condition." CP 424. She described how she had found him in the soiled utility room:

> All these briefs, all the diapers were from different patients who have different cases. So leaving him with soiled hands, dirty hands on the hallway, it would mean he would (Inaudible) to go to other patients and he would give this -- okay. Taken[sic] all the dirt into the rooms. So from my heart I couldn't accept that was not under the (Inaudible), uh, 'cause we're here to prevent the spread of bacteria and everything.

CP 424-25.

[4] Trainee Jalissa Harris, whom Ivan had just grabbed, was also present that night.

This Court should conclude that there is substantial evidence that Ms. Karanjah intervened in the presence of danger. The Court should therefore affirm the Superior Court's reversal of the Department's abuse finding.

C. The Law of the Case Doctrine Limits the Department to the Factual and Legal Inquiry in the Superior Court's 2014 Remand Order and the Undisputed Findings of Fact.

In its Response Brief at 16-18, the Department misinterprets the "law of the case" doctrine by alleging that an appellate court will generally not re-determine a rule of law from a prior determination in the same case or which was necessarily implicit in the prior ruling. However, this form of the "Law of the Case Doctrine" is inapplicable in this case. Rather, because the superior court acted in a limited appellate capacity, when issuing its 2014 remand order, the "Law of the Case Doctrine" applicable here occurs when an appellate court's determinations have a binding effect on further proceedings on remand. *Bunn v. Bates*, 36 Wn.2d 100, 216 P.2d

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741 (1950).[5]

1. The BOA Failed to Follow the Superior Court's Mandate Regarding Its Specific Application of the *Brown* Case.

The Department misleads this Court regarding the instructions in the 2014 remand order. The Department inaccurately describes the mandate as only requiring the BOA to "find additional facts regarding whether Ms. Karanjah injured or physically mistreated Ivan." Response Brief 17. However, it omits the specific instructions for applying the *Brown* holding.[6] The Superior Court's 2014 remand order required the Department to determine whether Ms. Karanjah's actions regarding Ivan were "reasonable," under the *Brown* case. CP 549. The Court required the

[5] The Department asserts that it "would be unconstitutional" if the Court applied the doctrine to an administrative agency. Response Brief 17. While there is no reported Washington jurisprudence on this particular question, the Ninth Circuit Court of Appeals recently held that, "as a matter of first impression," the law of the case doctrine and the rule of mandate both "apply in the social security context." *Stacy v. Colvin*, 825 F.3d 563, 567 (2016). Like the Department in the present case, the Social Security Administration is an executive agency that operates under administrative law.

The Department also argues that application of the "Law of the Case Doctrine" violates a separation of powers because it requires the executive branch to take a discretionary act. Response Brief 17-18. It cites to *Shaw v. Clallam County*, 176 Wn. App. 925-934-35, 309 P.3d 1216 (2013), for this proposition. However, *Shaw* dealt with a remand from the court to a public official, not a tribunal. The court specifically distinguished between these stating that remand to a public official can violate the separation of powers but remand to a tribunal does not.

[6] Earlier in the "Procedural History" section of its Response Brief, the Department briefly mentions that "the court determined that the Department did not properly apply the law in *Brown v. Dept. of Social and Health Services*, 145 Wn. App. 177, 185 P.3d 1210 (2008), and the case was remanded to apply that law. Response Brief 8.

Department to make this determination by considering all of the "surrounding circumstances," including:

> [Ms.] Karanjah's obligations to resident Ivan as a patient, i.e., as a state registered nursing assistant; Ivan's patient history, including a history of elopement; and the risk of harm that resident Ivan presented to himself and to others in the facility....

Id. The court also required the Department to determine, under *Brown*, whether Ms. Karanjah "inflicted actual bodily injury or physical mistreatment on Ivan." *Id.*

As discussed in the Opening Brief at 29-34, and further below, the Department did not apply *Brown* to determine the reasonableness of Ms. Karanjah's actions within context of the situation. Instead, it shifted the burden of proof and required Ms. Karanjah to prove an affirmative defense of self-defense and defense of others. AR 18-19. This Court should conclude that the Department erroneously interpreted and applied the law, and affirm the 2016 Superior Court order.

2. The Superior Court's 2014 Remand Order Did Not Reverse the Finding of Fact That Ms. Karanjah Released Ivan from Restraint Prior to His Hitting His Wrist and Entering His Room. That Finding Has Become the Law of the Case on Remand, and a Verity on Appeal.

The Department agrees that the Superior Court partially overturned only one finding of fact: "Ivan's wrist was injured when he hit it against the door-jab[sic], and that injury caused swelling and pain." AR 181.

According to the Department, "no other finding of fact was reversed by the Superior Court." *Id.* The parties stipulated that unless the Superior Court had reversed Findings of Fact and Conclusions of Law in the BOA's 2013 Order, those findings and conclusions would not be at issue on remand, and the decision-maker would not make contrary findings or conclusions. AR 193.

In a finding of fact that was labeled as a conclusion of law[7], the BOA previously found that Ms. Karanjah "released him at the door of his room[8], and he injured himself while flailing his arms, most likely for balance." AR 254. The Superior Court only reversed the part of this finding that relates to Ivan injuring himself. It did not reverse the portion regarding Ms. Karanjah "releas[ing] him at the door of his room" or the finding that he was "flailing his arms, most likely for balance." These undisturbed findings contradict the later BOA finding in the 2015 decision that Ms. Karanjah shoved Ivan through the door of his room (causing Ivan to hit his wrist on the doorjamb). The Court should conclude that the law of the case doctrine applies with respect to these undisturbed findings, and

[7] Findings of fact by an administrative agency, which are labeled as conclusions of law, will be treated as findings of fact when challenged on appeal. *Morgan v. Dep't of Soc. and Health Servs.*, 99 Wn. App. 148, 992 P.2d 1023, *rev. denied*, 141 Wn.2d 1014 (2000).

[8] This finding was misquoted in the Opening Brief as "at the foot of his door," rather than "at the door of his room." In either case, Ms. Karanjah would have released Ivan from restraint prior to entering his room.

that the contrary 2015 BOA findings exceeded the Department's authority.[9]

D. By Requiring Ms. Karanjah to Prove an Affirmative Defense of Self-Defense or Defense of Others, the Department Has Improperly Shifted the Burden of Proof to Her. RCW 34.05.570(3)(d)

The Department has incorrectly required Ms. Karanjah to affirmatively prove a "defense of self or others." The BOA failed to follow the Superior Court's mandate to determine on remand whether Ms. Karanjah's contact or restraint was "reasonable" under *Brown*, and in light of all of the surrounding circumstances."

Instead, the BOA's focus on "**The Defense of Self Defense and Defense of Others,**" improperly shifts the burden of proof and relies on an erroneous interpretation and application of *Brown*. AR 18-20. (emphasis added). The Review Judge concludes, "There simply was not the necessary immediacy of ***defensive*** action in this case that the Court of Appeals found was present in the Brown [sic] case." AR 19. (emphasis added).[10] In so doing, the Department Review Judge improperly restricted

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[9] Even if the Court concludes that the law of the case doctrine does not apply to this precise circumstance, the result is nevertheless the same. As Ms. Karanjah has argued, in APA judicial review proceedings, undisturbed findings of fact are verities on appeal, and necessarily on remand in this case. *Heidgerken v. State, Dep't. of Natural Res.*, 99 Wn. App. 380, 993 P.2d 934 (2000), *rev. denied*, 141 Wn.2d 1015 (2000).

[10] See Opening Brief at 31-34, for additional argument on this issue.

the legal analysis and applicability of the facts that would have supported Ms. Karanjah's actions.

The Department argues for applying the same burden-shifting standard that the Legislature recently declined to enact.[11] The *Brown* case states that when a caregiver intervenes in the presence of danger, conduct that is "protective, not injurious, or ill-intended" is not abuse. *Brown*, at 183. Nowhere in that case do the words "self-defense" or "necessity" appear.

The Department is now making a policy argument to shift the burden of proof in these cases. Response Brief 28-37. The Department does so because of an apparent disagreement with the *Brown* holding, and does so despite the Legislature's recent action declining to adopt amendments to the statute that could have shifted the burden of proof.

Even though it now argues for adoption of a necessity and self-defense standard, the Department failed to actually apply any of the elements for those defenses in Ms. Karanjah's case. Washington jurisprudence on necessity and self-defense is a complex and voluminous

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[11] The Department proposed, but the Legislature declined to adopt, a statutory amendment that would have imposed such a burden. *See* APPENDIX 2, and APPENDIX 3. The Elder Law Section of the Washington State Bar Association identified this potential problem with the proposed language. See APPENDIX 4 at 1. On behalf of over 600 members, the Section submitted a letter to one of the Senate sponsors of the legislation. The letter indicated that the language was based on "disagreement with the decision in *Brown v. DSHS*, 145 Wn.App.177, 185 P.3d 1210 (2008), and perhaps other cases." The letter conveyed concerns regarding a few items in the bill, and chief among those was the proposed "burden shifting" statutory defense. APPENDIX 4 at 3.

area of law. When the BOA chose to deviate from the Superior Court remand order, it required Ms. Karanjah to prove necessity and self-defense. The Department Review Judge, however, **did not cite to or apply the law** regarding the elements of those defenses. The closest the Review Judge actually came to articulating a legal standard was in concluding that:

> There simply was not the **necessary immediacy of defensive action** in this case that the Court of Appeals found was present in the Brown [sic] case."

AR 19. (emphasis added). That standard, to which the BOA held Ms. Karanjah, appears nowhere in the *Brown* case and it appears nowhere in Washington jurisprudence on necessity and self-defense. [12] The Court

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[12] In its Response Brief, the Department cites to some, but not all of the requirements for considering necessity and self-defense. For example, the Department argues that the "force used in self-defense is limited to what a reasonably prudent person would find necessary under the conditions as they appeared to the defendant." Response Brief 30.

Interestingly, the same case on which the Department relies for that objective standard, *State v. Walden*, 131 Wn.2d 469, 474, 932 P.2d 1237 (1997), also requires the application of a *subjective* standard. This standard requires the fact-finder to "stand in shoes of defendant and consider all facts and circumstances known to him or her." *Id.* at 479. The Department, however, has argued against applying a subjective standard, Response Brief 28, and the BOA Review Judge did not apply either of these standards in this case.

Even though the Department required Ms. Karanjah to establish "defense of others," the BOA did not cite to or apply the specific law on that topic. That law requires a determination regarding whether the "apprehension of danger as perceived by [the] actor," was "reasonable under the circumstances." *State v. Penn*, 89 Wash.2d 63, 66, 568 P.2d 797 (1977). The BOA never considered whether there was a "reasonable apprehension of danger" in Ms. Karanjah's case, nor does this term appear in *Brown*.

Similarly, to establish necessity, there must be a "good faith belief in the necessity of force and that such belief was objectively reasonable." *State v. Dyson*, 90 Wn. App. 433,

should conclude that the BOA improperly shifted the burden of proof to Ms. Karanjah, by requiring her to prove an affirmative defense. The Court should therefore affirm the 2016 Superior Court order.

E. The Review Judge's Characterizations of Ms. Karanjah as "Frustrated" and "Overly Assertive," are Based on Impermissible Speculation and are Not Supported by Substantial Evidence in the Record.

The Department argues that these characterizations, which appear in Conclusion of Law 17 of the 2015 BOA Order,[13] are "legitimate inferences." Response Brief 21. It is critical to distinguish between a permissible inference and impermissible speculation when either is the basis for a finding of fact. An "inference" is a "process in which one proposition (a conclusion) is arrived at and affirmed on the basis of one or more other propositions, which were accepted as the starting point of the process." *Poppell v. City of San Diego*, 149 F.3d 951, 954 (9th Cir. 1998). Federal courts have articulated the distinction between a permissible inference and impermissible speculation as follows:

> The line between a reasonable inference that may permissibly be drawn by a jury from basic facts in evidence and an impermissible speculation is not drawn by judicial idiosyncrasies. The line is drawn by the laws of logic. If there is an experience of logical probability that an ultimate fact will follow a stated narrative or historical fact, then the jury is given the opportunity to draw a

952 P.2d 1097 (1997). The BOA did not make any such consideration in Ms. Karanjah's case, nor did the court in *Brown*.

[13] AR 19.

> conclusion because there is a reasonable probability that the conclusion flows from the proven facts. As the Supreme Court has stated [in *Galloway v. United States*, 319 U.S. 372, 395, 63 S. Ct. 1077, 87 L. Ed. 1458 (1943)]: "The essential requirement is that mere speculation be not allowed to do duty for probative facts after making due allowance for all reasonably possible interferences favoring the party whose case is attacked."

Poppell v. City of San Diego, 149 F.3d 951, 954 (9th Cir. 1998). (quoting *Tose v. First Pa. Bank, N.A.*, 648 F.2d 879, 895 (3d Cir. 1981), as quoted in Ruggero J. Aldisert, *Logic for Lawyers: A Guide to Clear Legal Thinking* 26-27 (3d ed. 1997)).

Here, the Review Judge determined that it was Ivan's history of "improperly entering other resident rooms" and "combative assertiveness" that explained Ms. Karanjah's "frustration" and "over assertiveness." AR 19. There is not, however, a "reasonable probability that [this] conclusion flows from the proven facts."

Despite Ivan's combative and aggressive nature, Ms. Karanjah cared for him as a person. She would sing for him and had attended to him over a several month period. CP 410-11. Her sense of humanity, as well as Ivan's patient history, prevented her from leaving him alone in a hallway, undressed, with feces on his hands. CP 424-25. Because Ivan was not re-directable and only spoke Spanish, Ms. Karanjah needed to use some measure of restraint that avoided direct contact with his hands. There is no logical probability that the Review Judge's characterizations of Ms.

Karanjah as a "frustrated" or "overly assertive" follow from this "stated narrative" and these "historical facts."

The Court should conclude that the BOA engaged in impermissible speculation and that there is no substantial evidence that Ms. Karanjah was "frustrated" and "overly-assertive" with Ivan. The Court should affirm the Superior Court's reversal of the Department's abuse finding.

F. Ms. Karanjah Faced a Choice to Restrain Ivan or Risk Neglecting Him and Exposing Other Residents to Harm.

As a caregiver, Ms. Karanjah faced the dilemma of either walking away from Ivan, who had feces on his hands and risked infecting himself and others, or restraining him and escorting him to his room to be cleaned. Her dilemma was part of a no-win situation, but she made the only choice she could make, under the circumstances. Ms. Karanjah reiterates the arguments she made on this issue in the Opening Brief.

G. The Review Judge Did Not Properly Consider Ms. Karanjah's Legal Obligations under Other Statutory and Regulatory Authority, and Therefore Erroneously Interpreted and Applied the Law in Her Case. RCW 34.05.570(3)(d).

Ms. Karanjah reiterates her arguments on this issue from her Opening Brief at 46-47.

H. There Was Not Substantial Evidence to Support the 2015 Final Agency Order. RCW 34.05.570(3)(e).

1. <u>There Is No Substantial Evidence of an Injury to Ivan, or of a Nexus between Ms. Karanjah's Actions and Any Claimed</u>

Injury to His Wrist.

The Department argues that that there is substantial evidence that Ms. Karanjah caused an injury to Ivan's wrist. It relies, however, on "pre-remand" evidence that the Superior Court determined in 2014 was not substantial and did not rise to the level of physical abuse. Response Brief 13-16. The only new evidence the Department cites relates to the new BOA finding of fact that Ms. Karanjah pushed Ivan *through* the doorway to his room (thereby causing him injury). AR 9. As argued above, this finding is contrary to the undisturbed finding that she released Ivan from restraint *prior* to his hitting his wrist and entering his room. AR 254.

Ms. Karanjah reiterates her arguments on this issue in the Opening Brief, 38-42.

2. There is No Substantial Evidence That Ms. Karanjah Physically Mistreated Ivan.

Ms. Karanjah reiterates her arguments on this issue from the Opening Brief, 42-44.

I. The 2015 Final Order Was Arbitrary and Capricious. RCW 34.05.570(3)(i).

Ms. Karanjah reiterates her arguments on this issue from her Opening Brief at 46-47.

J. Ms. Karanjah Is Entitled to an Award of Attorney Fees for This Level of Review, and this Court Should Also Affirm the

Superior Court's Award of Attorney Fees for That Court's Level of Review. RCW 4.84.340-360.

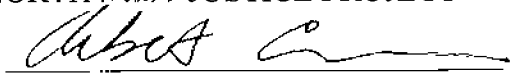
Ms. Karanjah reiterates her arguments on this issue from her Opening Brief at 47-48.

III. CONCLUSION

For the reasons described above, as well as in the Opening Brief, Petitioner Alice Karanjah requests that the Court affirm the 2016 Superior Court's reversal of the Department's abuse finding.

RESPECTFULLY SUBMITTED this 12th day of October 2016.

NORTHWEST JUSTICE PROJECT



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IV. CERTIFICATE OF SERVICE

I, ALBERTO CASAS, hereby certify under penalty of perjury under the laws of the State of Washington that on October 12, 2016 I caused a true and correct copy of *Respondent's Reply Brief* to be served on William McGinty by email to WilliamM1@atg.wa.gov , by prior agreement between the parties, and also by sending a copy by U.S mail, first-class postage prepaid addressed as follows:

William McGinty, Assistant Attorney General
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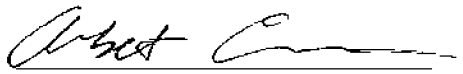
DATED this 12th day of October 2016, at Tacoma, Washington.



Alberto Casas

APPENDIX 1

WAC 246-16-810

Sanction schedule—Practice below standard of care.

PRACTICE BELOW STANDARD OF CARE				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	A – Caused no or minimal patient harm or a risk of minimal patient harm	Conditions that may include reprimand, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Caused moderate patient harm or risk of moderate to severe patient harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	C – Caused severe harm or death to a human patient	Oversight for 3 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. In addition - demonstration of knowledge or competency.	Permanent conditions, restrictions or revocation.	3 years - permanent

[Statutory Authority: RCW **18.130.390**. WSR 09-15-190, § 246-16-810, filed 7/22/09, effective 8/22/09.]

APPENDIX 2

Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Judiciary Committee

HB 1726

Title: An act relating to modifying certain definitions concerning vulnerable adults, including the definitions of abuse and sexual abuse.

Brief Description: Modifying certain definitions concerning the abuse of vulnerable adults.

Sponsors: Representatives Moeller, Jinkins, Tharinger and Appleton; by request of Department of Social and Health Services.

Brief Summary of Bill

- Makes changes to the definitions of "vulnerable adult," "abuse," and other terms applicable to abuse of vulnerable adults.
- Creates an affirmative defense to an allegation of physical abuse or improper use of restraint if the conduct was necessary to prevent an imminent danger of a substantial likelihood of harm.

Hearing Date: 2/5/15

Staff: Omeara Harrington (786-7136).

Background:

The Department of Social and Health Services (DSHS) investigates allegations of abandonment, abuse, financial exploitation, self-neglect, and neglect of vulnerable adults. The statutes regarding vulnerable adults require certain persons to report suspected incidents of mistreatment to the DSHS, and, in some cases, to law enforcement. Individuals found to have abused a vulnerable adult are prohibited from being employed in the care of vulnerable adults. In addition, a vulnerable adult, interested person on behalf of a vulnerable adult, or the DSHS may file a petition for an order for protection of a vulnerable adult who has been abandoned, abused, financially exploited, or neglected, or is threatened with such.

A vulnerable adult includes a person who:

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

- is 60 years of age or older and has the functional, mental, or physical inability to care for himself or herself;
- is found to be incapacitated (meaning the individual is at a significant risk of personal harm based upon a demonstrated inability to adequately care for himself or herself);
- has a developmental disability as defined in statue;
- is admitted to a facility;
- is receiving services from a home health, hospice, or home care agency, or an individual provider; or
- self-directs his or her own care but receives services from a personal aide.

"Abuse," as it pertains to mistreatment of vulnerable adults, is defined as willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation:

- Sexual abuse refers to nonconsensual sexual contact, or sexual contact between a vulnerable adult and a facility staff person.
- Physical abuse is the willful infliction of bodily injury or physical mistreatment, and may include the use of physical or chemical restraints in a manner that is inappropriate or inconsistent with licensing requirements.
- Mental abuse is any willful action or inaction of mental or verbal abuse, including but not limited to: coercion, harassment, inappropriate isolation from friends, family, or regular activity, and verbal assault that includes ridicule, intimidation, yelling, or swearing.
- Exploitation is an act of forcing, compelling, or exerting undue influence over a vulnerable adult, causing that vulnerable adult to act inconsistently with relevant past behavior or causing the vulnerable adult to perform services for the benefit of another.

"Financial exploitation" is defined separately than "exploitation" and is the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of a vulnerable adult for any advantage other than the vulnerable adult's profit or advantage.

Summary of Bill:

Several changes are made to the definitions of terms concerning vulnerable adults.

The definition of vulnerable adult includes any person the DSHS reasonably believes to have a developmental disability based on school or medical records (in addition to persons who have a developmental disability as defined in statute).

Abuse includes financial exploitation, as well as personal exploitation. Additionally, abuse includes the improper use of restraint against a vulnerable adult, meaning the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline in manner that is: (i) inconsistent with facility licensing or certification requirements; (ii) is not medically authorized; or (iii) otherwise constitutes abuse.

- Chemical restraint is defined as the administration of any drug to manage a resident's or client's behavior in a way that reduces the safety risk to the resident or others, restricts the resident's freedom of movement, and is not standard treatment for the resident's medical or psychiatric condition.
- Physical restraint is defined as the application of physical force without the use of any device, for the purpose of restraining the free movement of a resident's body. Physical

restraint does not include briefly holding without undue force in order to calm or comfort, or holding a hand for safe escort from one area to another.
- Mechanical restraint means any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

Sexual abuse includes nonconsensual sexual conduct, or sexual conduct between a vulnerable adult and a facility staff person, rather than sexual contact.

Mental abuse is a willful verbal or nonverbal action (rather than a willful action or inaction of mental or verbal abuse) that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling or swearing.

It is a defense to an allegation of physical abuse or improper use of restraint that the alleged perpetrator reasonably acted to prevent an imminent danger of a substantial likelihood of harm to any person, the conduct was necessary to prevent the harm, and the conduct was proportional to the danger. This defense must be proven by the alleged perpetrator by a preponderance of the evidence.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

APPENDIX 3

SENATE BILL REPORT
SB 5600

As of January 30, 2015

Title: An act relating to modifying certain definitions concerning vulnerable adults, including the definitions of abuse and sexual abuse.

Brief Description: Modifying certain definitions concerning the abuse of vulnerable adults.

Sponsors: Senators Dammeier, Keiser, Darneille and Kohl-Welles; by request of Department of Social and Health Services.

Brief History:
Committee Activity: Human Services, Mental Health & Housing: 2/02/15.

SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

Staff: Lindsay Erickson (786-7465)

Background: The Abuse of Vulnerable Adults Act (Act) authorizes the Department of Social and Health Services (DSHS) and law enforcement agencies to investigate complaints of abandonment, abuse, financial exploitation, neglect, or self-neglect of vulnerable adults. The Act requires mandatory reporting and investigations. It also allows vulnerable adults to seek protection orders or file civil suits for damages resulting from abandonment, abuse, exploitation, or neglect.

A vulnerable adult includes a person who:
- is 60 years of age or older who has the functional, mental, or physical inability to care for himself or herself;
- is found to be incapacitated;
- has a developmental disability;
- has been admitted to any facility such as an assisted living facility, nursing home, adult family home, soldiers' home, or residential rehabilitation center;
- receives services from home health, hospice, or home care agencies;
- receives services from an individual provider; or
- who self-directs their own care and receives services from a person aide.

Summary of Bill: The definition of abuse includes personal or financial exploitation of a vulnerable adult. Abuse also includes improper use of restraint against a vulnerable adult, which means the inappropriate use of chemical, physical, or mechanical restraints for

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This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

convenience or discipline or in a manner that: (1) is inconsistent with facility licensing or certification requirements; (2) is not medically authorized; or (3) otherwise constitutes abuse under this section.

Chemical restraint means the administration of any drug to manage a resident's or client's behavior in a way that reduces the safety risk to the resident or others, has the temporary effect of restricting the resident's freedom of movement, and is not standard treatment for the resident's medical or psychiatric condition. Physical restraint means the application of physical force without the use of any device, for the purpose of restraining the free movement of a resident's body. The term physical restraint does not include briefly holding without undue force a resident or client in order to calm or comfort the client, or holding a resident's or client's hand to safely escort a resident from one area to another. Mechanical restraint means any device attached or adjacent to the resident's body which the resident cannot easily remove that restricts freedom of movement or normal access to the resident's body.

Mental abuse means a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Sexual abuse means any form of nonconsensual sexual conduct.

A vulnerable adult includes a person who DSHS reasonably believes has a developmental disability based on school or medical records.

It is a defense to an allegation of physical abuse or improper use of restraint that the alleged perpetrator reasonably acted to prevent an imminent danger of a substantial likelihood of harm to any person, the alleged perpetrator's conduct was necessary to prevent the harm, and the alleged perpetrator's conduct was proportional to the danger. It is the alleged perpetrator's duty to prove this defense by a preponderance of the evidence in any civil adjudicative hearing.

Appropriation: None.

Fiscal Note: Not requested.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

APPENDIX 4

Elder Law Section

of the Washington State Bar Association

VIA EMAIL, Bruce.Dammeier@leg.wa.gov

The Honorable Bruce Dammeier
205 Irv Newhouse Building
PO Box 40425
Olympia, WA 98504

RE: SB 5600

Dear Senator Dammeier:

On behalf of the over 600 members of the Elder Law Section, I write to express our concerns with SB 5600, which seeks to make changes to RCW 74.34.020 and 205.

First, I must emphasize that **the Elder Law Section does not condone abuse, neglect, or exploitation of vulnerable adults.** Indeed, elder law attorneys often work to prevent mistreatment of vulnerable adults; to rectify the harms caused by such mistreatment; and when possible, to obtain justice for the vulnerable adults who are subject to it. The Vulnerable Adult Protection Act, RCW 74.34, has proven itself a valuable tool in these efforts. In an effort to maintain the integrity of the Act, this letter is intended to alert you to the legal concerns we see in SB 5600 as drafted.

Next, I would like to emphasize that **the Section supports DSHS in its efforts to protect vulnerable adults.** We have recently taken steps to ensure that DSHS and the Section are regularly communicating about legislation relevant to both entities. Going forward, we hope to work more closely with DSHS and its attorneys if similar bills are developed.

Brief Overview of RCW 74.34

A hallmark of RCW 74.34 is the provision of multiple tools that may be used alone or together in the effort to protect vulnerable adults. The options are as follows:

(1) **Investigations and administrative proceedings**, initiated by Adult Protective Services (APS);

(2) **Vulnerable Adult Protection Orders**, sought by a vulnerable adult, an interested person, or APS;

(3) **Civil law suits for damages in superior court**, filed by a vulnerable adult or by a vulnerable adult's family member, guardian, legal fiduciary, or estate.

Administrative and superior court proceedings under chapter RCW 74.34 are

governed by relaxed rules of evidence. *See, e.g.*, ER 1101; RCW 34.05.425(1); *Ingram v Dep't of Licensing*, 162 Wash.2d 514, 524, 173 P.3d 259 (2007). For example, hearsay evidence is permitted.

Concerns Regarding SB 5600

As a threshold matter, it is important to note that any changes made by SB 5600 will apply to all of the legal tools available under RCW 74.34. Because SB 5600 originated as department-request legislation, it is unclear whether the implications of these changes have been considered beyond the way they would be utilized by APS, as opposed to other parties who seek RCW 74.34 remedies. In addition to that general issue, below is an explanation of additional concerns regarding SB 5600.

(1) Subjective Criteria

RCW 74.34 currently uses objective criteria to include persons with developmental disabilities in the definition of "vulnerable adult." RCW 74.34.020(17)(c) states that a person who has "a developmental disability as defined under RCW 71A.10.020" is a vulnerable adult. In turn, RCW 71A.10.020 defines "developmental disability" by reference to (1) a list of diagnosable conditions; (2) that originate by a specified age, (3) continue for an indefinite period, and (4) constitute a significant limitation to the individual.

In contrast, SB 5600 would utilize subjective criteria to expand the definition of vulnerable adult to include a person who "***the department reasonably believes*** has a developmental disability based on school or medical records." *See* Sec. 1(20)(c) (emphasis added). This definition raises substantial questions. For example, how would DSHS obtain school or medical records, absent consent by the person DSHS believes is a vulnerable adult? What would happen if school or medical records do not provide the basis for a reasonable belief? How would this definition be utilized by private individuals seeking to use the legal tools available under RCW 74.34? How would a superior court, in a proceeding commenced by a private individual, know what DSHS "reasonably believes"? We would be happy to work with DSHS, its attorneys, and other stakeholders to understand the reasons this change is being sought, and, if possible, to seek more appropriate solutions.

(2) Defense of Self or Others

SB 5600 Sec. 2(3) expands RCW 74.34.205 to provide a defense for an alleged perpetrator of "physical abuse" or "improper use of a restraint" to prove the action taken was in defense of self or others. The alleged perpetrator must demonstrate that action was taken "to prevent an imminent danger of a substantial likelihood of harm to any person" and that "the conduct was proportional to the danger." As we understand, this language is based on disagreement with the decision in *Brown v. DSHS*, 145 Wn.App.

177, 185 P.3d 1210 (2008), and perhaps other cases. In cases such as *Brown*, the courts have asked whether the alleged perpetrators intended to cause harm to vulnerable adults. Finding that they did not, these courts have ruled against DSHS. Below we set forth two problematic aspects of the newly added language as well as potential consequences.

a. Burden Shifting

When DSHS accuses someone of abuse, they have the burden of proof, just like the state has the burden of proof when they accuse someone of a crime. If DSHS accuses a person of physical abuse, they have to prove, by a preponderance of the evidence, that the person did a "willful action of inflicting bodily injury." If DSHS accuses the person of improper use of restraint, they have to prove "inappropriate use" of the restraint. *See* RCW 74.34.020(2)(b),(e).

However, the proposed bill flips the burden of proof for these two accusations, and requires the person to prove that the action was not physical abuse, or to prove that the restraint was not inappropriate. This is an unprecedented shift in the burden of proof. It is being proposed in an area of law where the outcome of being found guilty is devastating to the person, prohibiting them from working with or even volunteering around vulnerable adults or children for the rest of their lives.

The burden shift proposal by DSHS will exacerbate an approach already being taken by DSHS in these cases. In RCW 74.34, the concept of intent is expressed through the term "willful"— but the statute does not define this term. Under APS regulations, the term willful is defined as "nonaccidental action or inaction by an alleged perpetrator that he/she ***knew or reasonably should have known*** could cause harm, injury or a negative outcome." *See* WAC 388-71-0105 (emphasis added). This definition is akin to a negligence standard. Since the *Brown* decision, however, courts have held that "willful" requires a willful act and the intent to cause injury. If SB 5600 passes, APS could continue to argue intent under the lower negligence standard, and then the burden would ***unfairly shift*** to the alleged perpetrator to prove lack of intent under the higher standard of the new language in SB 5600.

b. Substantial Likelihood of Harm

Another significant concern is the meaning of "imminent danger of a substantial likelihood of harm." The "substantial harm test" as we apply it means that a person may only restrain a vulnerable adult from committing assault in the first or second degree, because assault in the first or second degree has a "substantial bodily harm" component. *See* RCW 9A.36.001; .021. By contrast, a person who restrained a vulnerable adult from committing assault in the third degree (such as slapping a transit operator, a nurse, or clerk of the court) would not be able to satisfy the burden shift proposed by DSHS. Further, a parent would not be able to restrain an adult child from pinching another person because pinching could constitute assault in the fourth degree, which does not require "substantial" harm. See RCW 9A.36.04. Any attempts to stop such conduct

could be met with an abuse finding—an outcome that carries severe consequences as explained in the next section.

c. Severity of Consequences

Given the implications of an abuse finding by DSHS, the problems explained above are even more significant. The name of an individual who has been administratively found to have abused, neglected, or exploited a vulnerable adult is placed on a registry. Once in the registry, the individual's name is never removed. The implications of being placed on the registry are that the individual will be precluded from providing services to vulnerable individuals forever; and, in some instances, prohibited from having contact with the vulnerable individual, who may be a family member. With such potential outcomes, the burden of intent should not be unfairly shifted and the potentially absurd results that could flow from the likelihood of harm issue should be addressed.

Again, we would be happy to work with DSHS, its attorneys, and other stakeholders to understand the reasons for the addition of the defense language, and, if possible, to seek more appropriate solutions.

(3) Inconsistent Language

SB 5600 provides new definitions for the terms "improper use of restraint," "chemical restraint," and "mechanical restraint." Although the definition of "improper use of restraint" has broad application, the definitions for "chemical restraint" and "mechanical restraint" refer only to use of such restraints on a resident or a client. The terms "resident" and "client" are not defined. It is unclear whether the prohibition against chemical and mechanical restraints is intended to apply only to "residents" of facilities subject to state licensure rules, or whether it is intended to be limited in an additional or different way.

Thank you for your consideration of our input. We look forward to working with you and other stakeholders to continue to protect and prevent harm to vulnerable adults.

Sincerely,

Carla Calogero
Chair-Elect
Elder Law Section

cc. Bea Rector, Director, Home and Community Services, RectoBM@dshs.wa.gov

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Case Name: Alice Karanjah vs. DSHS

Court of Appeals Case Number: 48666-1

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Affidavit

Letter

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